ImpAct

- sharing experience
- defining good practice
- improving service delivery
- supporting learning in the NHS

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NHS Learning Network

NOT ANOTHER NEW PUBLICATION?

Everyone involved in creating something new has a belief that what they are doing is needed, that it is something that people have been waiting for. They assume that others will be just as enthusiastic as they are. There is always a danger of forgetting that people in the NHS are being deluged by paper from all quarters.

We were no different as we planned to create ***ImpAct*** - so it's been encouraging to get messages from many readers expressing support for our efforts. We've had encouraging messages by email, by letter, by phone and personally at conferences.

Many people have said that ***ImpAct*** fills a big hole and that there is no other publication that concentrates on reporting on the lessons people are learning about implementing change. The response to local initiatives we have featured has been equally encouraging, with people getting lots of phone calls and letters asking for more details and copies of the papers they have produced.

But we know the danger of complacency and are planning to explore ways that we can evaluate more thoroughly the reactions and responses to our efforts and find ways to improve ImpAct. We now know also that impact is a popular word in the NHS – there are several other impact projects.

Who should read ImpAct ?

Two questions that a number of people have raised are *who is **ImpAct** for?* and *why is it different from **Bandolier**?* Our view is that:

- ***Bandolier*** is of prime interest to practising clinicians - with the expectation that (practice and service) managers will be interested and learn from it, whereas
- ***ImpAct*** is of prime interest of managers - but also of interest to clinicians so that they can better understand issues about implementing change etc.

We hope both bulletins will interest those involved in education, training and research.

In this issue of ***ImpAct***, the two cardiac projects should be of particular interest to clinicians and managers. The sexual health service case study will interest service managers and the training case study will interest those involved in training, and also GPs. The way in which walking for a healthy heart was introduced for older adults is brilliant, and a superb example of how different parts of the public services can work together with the community.

SPEEDING UP CARDIAC CARE

Creating a rapid access chest pain clinic in Newham, East London

Why was the initiative launched?

Growing recognition that the outpatient service was unsatisfactory prompted action by the Cardiology Department at Newham Hospital. Waiting times were lengthening and putting patients at risk. These problems were strengthening local GPs' demands for open access to a range of cardiac diagnostic procedures such as ECG and exercise testing.

Local Consultants were reluctant to support the development of open access facilities that would simply report on the results of the individual test without the benefit of clinical opinion. This dilemma prompted the examination of ways to speed up the assessment and diagnosis of patients with chest pain in ways that would not unduly hamper already stretched local cardiac services.

What was done?

Discussions between representative local GPs and the Department of Cardiology agreed that the solution might be to develop a local rapid access chest pain clinic. The clinic would offer a prompt diagnostic service for a limited group of patients. Criteria to guide referral to the clinic were agreed. The new clinic would not be a substitute for the existing mechanism for emergency referrals for suspected acute myocardial infarction and unstable angina.

Rapid access Chest Pain Clinic – referral criteria

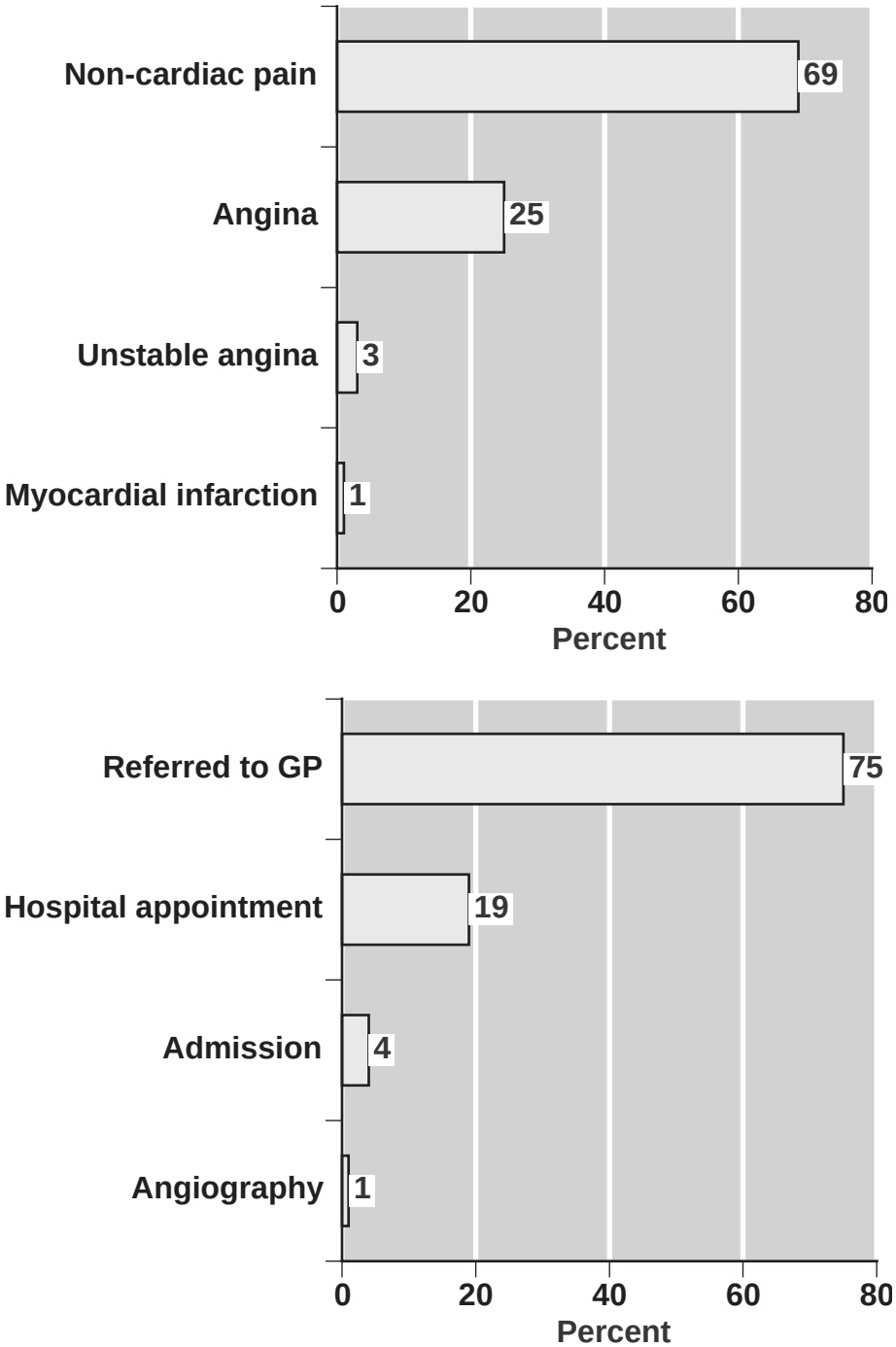
- No previous history of treatment for coronary heart disease.
- Recent onset of chest pain, i.e. within the last 2 to 4 weeks.
- Age limits: men under 30 years and women less than 40 years would not be seen.

In ImpAct 3

To accommodate the new clinic, adjustments were made to the cardiology work programme and time set aside for the clinic to operate from 12 noon until 2 pm every weekday. The clinic would be led by Dr Ranjadayalan and cardiologists would man the clinic on a rota basis. Any necessary test would be done immediately. The siting of the clinic within the hospital would enable the full range of diagnostic tests to be undertaken like ECG, exercise testing, X-ray etc. The local GP fundholding group (at the time) agreed to meet the additional costs involved.

A dedicated fax line was set aside within the Cardiology Department allowing immediate referral from primary care practices to the clinic. Patients referred by GPs in a morning would be seen at the clinic on the same day: those referred in the afternoon seen the following day. There was a guarantee that patients meeting the referral criteria would be seen within 24 hours. The fax line would be accessible only to medical staff to safeguard patient confidentiality.

Figure: Diagnoses and outcomes in about 2,160 patients referred to the new clinic



A computer-based proforma was designed to guide the cardiac assessment. This included a limited range of information fields: the use of drop-down menus simplified completion. Associated software created a computer-generated report for the GP. The letter was semi-structured with details of diagnosis, cardiac history, risk factors, investigation results and recommended treatment and follow-up arrangements. The report was faxed to the GP as soon as the consultation was completed.

When hospital-based care and treatment is required patients are given appointments for the regular cardiology outpatient clinic: follow-up would not be managed within the Rapid Access Chest Pain Clinic.

Is it working?

Since the new service was launched in January 1996, about 75 patients each month are being seen at the clinic, with the number growing steadily each year (Table). The service is well regarded by local GPs and patients. The mechanism for providing prompt computer-generated reports has been well received. A recent local study, using a detailed questionnaire sent to the 120 GPs who refer to the new service, showed that over 80% of GPs preferred the new approach when compared with the traditional dictated letter.

The diagnoses made in the first 2160 patients are shown in the Figure. Sixty-nine percent of cases had chest pain of non-cardiac origin. Most patients (75%) could be referred back to the GP after the diagnosis. Admission or additional tests like angiography were rare, but 19% of patients had a subsequent hospital clinic appointment.

The operation of the clinic is discussed regularly with local GPs as part of the local CME programme. Experience has shown that the sessions are helpful to GPs – normally about 50 GPs attend the sessions that are organised every six months. Case studies based on recent referrals are used as to illustrate good practice and for example to stress that those patients who did not meet the criteria would not be seen. They would be offered an early appointment at the 'normal' outpatient clinic.

The new service has had no noticeable impact on other local cardiac work within the hospital – the pressure on the outpatient clinics continues. Reflecting the number of patients seen at the clinic and their more prompt assessment, it is very likely that the service has had an impact of local cardiac health. After initial funding from the local fundholding GPs, support continues through the local PCG.

Table: Referrals to the new clinic over three years

Year	Total patients	Monthly range	
		Low	High
1996	592	30	70
1997	734	45	81
1998	853	53	86

Tips for success

√ Get the criteria for the new service right and agreed – and stick to them.
√ Make the service user-friendly – keep promises to GPs and see patients, and report on them promptly
√ Make communications between the hospital clinic and primary care practices reliable and safe.

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The following materials are available:

- The protocol - with full criteria for access to the clinic.
- The input proforma (used in the clinic).
- A sample of the (report) letter/fax to the GP.

ImpAct bottom line

⇒ **Make new services work and be successful, so good that ways have to be found to resolve any funding issues.**

Sexual health: Finding practical ways of integrating services

Lessons from the experience in the Sexual Health Service at Thameside Community Healthcare NHS Trust

Why was the initiative launched?

The publication of Health of the Nation prompted questions by South Essex Health Authority about the high rate of local teenage pregnancy because it had the third highest in the (then North East Thames) region and higher than many inner London districts. Subsequent discussions with local NHS Trusts identified the fragmented nature of local sexual health services as a cause for concern. The rise in rates seemed to coincide with cuts in the level of family planning services. It was argued that *if cutting services had caused the problem - we should be able to solve the problem by developing a new sexual health service*. The decision was taken to explore how to achieve a fully integrated sexual health service.

What was done?

The initial step brought the separate components into a single entity, an integrated Sexual Health Service, with a service manager. There had been five separate services (box). All had different histories, traditions and funding arrangements. They were widely spread across local organisations and geographically.

The single service structure led to some initial success, born on the better communications which the new structure provided. But there was a concern that these successes were simply scratching the surface. They were not tackling the real sexual health issues in the community such as teenage pregnancies and sexually transmitted infections. The interventions continued to be provided from separate boxes with little regards to wider questions about sexual health and its important influence on patients general well being.

It was increasingly recognised that the complex problems being tackled required joined up solutions. To help the drive towards a joined-up solution the focus was on a shared understanding of the similarities and differences between the two largest elements of the service, i.e. family planning and genito-urinary medicine.

The very nature of these services presented real barriers to integration (Table on page 4). Training and educational initiatives were organised to try to overcome these barriers and improve relationships. For example to help staff in the family planning service understand the issues involved in managing sexually transmitted diseases and vice versa. These initiatives were well received and successful. Increasingly, the

Sexual Health Services – main components

- Family Planning
- Genito-Urinary Medicine
- HIV/AIDS Care Team
- Sexual Health Promotion
- Young Peoples Advisory Service

The Hairdressers Project

Twelve local women's hairdressers were recruited, provided some basic training on sexual health, a supply of condoms and information about the full range of services. Condoms on the counter opened the door for conversations about sexual health to come up in conversation and the hairdressers were able to provide reliable information. An improvement on the traditional image of the men's hairdressers.

service was able to portray itself as 'integrated' and secure funding for a series of important developments, including initiatives to promote sexual health with schools, voluntary organisations and local authorities.

Although the initiatives did not seem to be having any noticeable impact on integration when seen from within the organisation, the quality of services being provided was improving. For example, when staff from individual services were working with other organisations, such as providing sessions in the 21 local secondary schools, they were increasingly involving their colleagues from other services. The fact that they were part of one service seemed to be improving collaboration between parts of the service and different disciplines. An integrated service was being provided to patients.

Durex award

An OFSTED inspection of a local college commended the sessions provided by a family planning nurse in a local college and the services and support which were available for students. Similarly, a local community development initiative The Hairdressers Project (Box) won the first ever Durex Award for innovation in sexual health.

A major landmark was achieved in December 1997 when the service won its Charter Mark for the quality of service it was providing to its customers, both patients individually and other local partner organisations.

These successes demonstrated that ***the*** key measure of success in integration rested on relationships with other organisations and the extent to which the service was outward looking rather than any internal analysis. The essential feature was the quality of the relationships between the NHS based sexual health service and other services in the community. That relationship provided the basis on which influence could be brought to bear. The real challenge of integration was to get the NHS, the voluntary sector, other public sector organisations (schools, residential homes etc) and commercial organisations working in harmony to tackle the sexual health needs of the community, with each partner understanding the role played by others.

Tips for Success

- √ Services that are outward looking and which care about how they are perceived by others are the more likely to succeed.
- √ Demonstrate that the reason for bringing services together is to improve service quality rather than reduce costs.
- √ Don't be lulled into believing that tidy organisation charts are an answer to service integration.
- √ Create reliable communications channels to keep all staff informed about new developments.
- √ Invest in training: allow staff time to learn about and understand the roles played by others and to push back professional boundaries.
- √ Remember that well motivated staff require a supportive environment to give their best.

What happens next? - working with primary care

The current challenge is to explore how the lessons so far learnt can guide the service as it looks towards closer collaboration with primary care groups. Again there are differences in perception, for example GPs often argue that they already provide family planning advice so why do we need a family planning service? Closer examination will show that they are providing complementary rather duplicate services. GPs and primary care teams tend to support women whose concern is to space their family while women whose principal concern is to avoid pregnancy use the Family Planning Service.

The lessons about being outward-looking are already bearing fruit. Discussions are starting from the premise of how can the sexual health service support the primary care team. Work is in hand to explore ways enhancing skills and knowledge, of promoting the uptake of the services provided by all parties and to tackle adverse health and social outcomes including teenage pregnancies. The early spirit of co-operation augurs well for the future.

Table: Comparison of the key features of the Family Planning service and Genito-Urinary Medicine Service

	Family Planning Service	Genito-Urinary Medicine
Leadership	Nurse-led service	Consultant led service
Staffing	Large numbers of part-time staff	Small full-time staff
Structure	Evening clinics	Day-time clinics
Physical base	Community based	Hospital

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ImpAct bottom line

⇒ **Services that are outward-looking and which care about how others perceive them are more likely to suceed. Influence is born of good relationships, not internal structures and systems.**

EQUIPPING JUNIOR DOCTORS FOR A CAREER IN PRIMARY CARE

Finding ways to improve the quality of senior house officer posts around Portsmouth

Why was the initiative launched?

The last five years have seen the introduction of better educational structures for house officer and registrar grades but there have been no equivalent developments for the senior house officer grade. At this level the service commitment starts to overshadow the educational component of training posts. The publication in 1999 by the GMC of The Early Years was an attempt to describe what should be done. The real challenge is in making change happen.

The need for change was particular evident in general practice training. But the problems are often anecdotal and attempts to introduce change have been hampered by lack of information about each specific senior house officer post. The aim of this project was to improve the training by developing a mechanism for securing the views of SHOs on existing training posts.

What was done?

The work was based in two district general hospitals in Portsmouth. The first step involved the appointment of a course organiser in 1993 responsible for senior house officers training in general practice. Time (one session per week) was set aside specifically to enhance the general practice contact with, and improve the educational content of, senior house officer posts on general practice vocational training schemes. The work was overseen by the associate director and director of general practice education and the dean of postgraduate education.

From the beginning it was clear that a mechanism was required to assemble information about the posts and views on the quality of training provided. Comparisons over time and between posts would be essential. Current routine systems could not provide the information required so a questionnaire was designed which could be used six-monthly i.e., at the end of each posting. The design was based on experiences reported by others and the local design was piloted and assessed for validity and reliability.

Following the successful pilot, the questionnaire has been applied in the same format since 1994: it continues to be applied every six months. Data is assembled by Joan Dunleavy of the Wessex Research Network and reviewed by Mark Mullee of the Department of Computing and Statistics at Southampton University. Second mailings and telephone reminders achieve response rates of 95 to 100% where appropriate. Anonymised data is fed back in a variety of ways, by tables, bar charts etc. Data from the questionnaire is used alongside information collected from statements from senior house officers, consultants, course organisers, and clinical tutors and data available from other sources such as attendance register. So far 64 SHOs have taken part in the work as they rotated through sixteen different posts on the GP vocational training scheme.

Problems suspected in posts have been confirmed such as low rates of induction, appraisal systems and contact with general practice. New problems that emerged were difficulty in obtaining study leave, low rates of consultation before contract changes, lack of clarity about routes for complaints, and lack of awareness about stress support. The system now in place allows information about the training posts to be provided on a regular basis to the course organisers and consultants involved. Care has been taken to ensure that the reports cover positive messages, where posts were doing well, as well as evidence of the need for change.

SHO Questionnaire

Structure

- 29 questions – yes/no and category 1-5 replies
- Two sheets of A4 - completion time c. 5 minutes

Content

- Contractual status
- Working conditions
- Educational content
- Opinion on overall post
- Demographic details

Based on SHO Educational Audit Project (SEAP) questionnaire

Selected responses (1994-1998)

	1994	1996	1998
Number	21	26	22
Induction arrangements	48	27	72
Personal educational targets	24	65	45
Met GP trainer six monthly	52	46	95
Named educational supervisor	86	73	91
First appraisal	23	58	59

Has it made a difference?

Some examples of the changes, which have followed the introduction of the system, are:

- Introduction of GP orientated teaching sessions for all SHOs on a training rotation.
- Regular contact by almost all (95%) of SHOs with their GP trainers.
- Reintroduction of teaching sessions to a post where this had been discontinued.
- An increase in appraisal (from 25% to 59%) of SHOs after consultants appraisal training.
- An increase in attendance at teaching sessions from 41% to 65%.

Since the completion of the development work, the questionnaire has been taken up by Southeast Scotland Region under Dr William Patterson as Director of Education and in other centres in the South and West. There has also been an increase in the number of course organisers being given specific responsibility for senior house officers training in general practice (scheme organisers) locally.

Tips for success

√ Leadership is important, and the appointment of one person to manage SHO training will increase the chance of success.

√ Build systems to provide reliable information about the nature and scale of problems.

√ Comparisons over time will be essential, so that the effect of interventions can be assessed and followed up.

√ Make sure that your 'communications' are effective so that those who need to know do know about problems in training.

√ Help people to change by providing opportunities for discussion and where necessary further information about the justification for change.

√ Explicit statements of expected standards are needed to maintain momentum for change.

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An information pack is available; including leaflets on the *New Deal* and *Education Agreement* for Wessex, a job description, questionnaire, study leave guidance, appraisal guidance, and an induction pack for SHOs. The pack includes also other recommended reading.

ImpAct bottom line

⇒ **Make sure that you know what needs to change before making detailed plans. Don't rely on anecdotes. Make sensible use of questionnaires.**

ImpAct

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ImpAct is about 'good practice' - and about **imp**lementing change and **act**ion to get there! We want to help people in the NHS to make a difference, and to identify and report on:

- Ways of improving performance which have been successful and which are transferable.
- People who have led successful local initiatives and who are keen for others to learn from their experience.
- Material developed locally that could be adapted for use elsewhere and thus cut local development time.

Let ***ImpAct*** know if you have done something that made a difference and want to tell others how you did it.

EXERCISING THE WAY TO BETTER CARDIAC HEALTH

Developing a systematic way of getting patients to exercise.

Why was the initiative launched?

After a busy day in the surgery in 1994, Dr William Bird, a GP in Sonning Common, went for a walk in the evening and began to ponder why his patients seemed to be unwilling to exercise. Few patients seemed to accept advice that exercise would be good for them: it could significantly reduce their risk of coronary heart disease. Walking on footpaths in the local woodland he noticed that he was alone. No one else was using the footpaths. He decided that he would look for ways to tackle the problem. How could he get his patients walking?

What was done

The practice decided that a structured approach, offering a detailed prescription about what patients should do, might be successful. Subsequent discussions led to the creation of a set of leaflets for a series of walks around Sonning Common. The leaflets provided instructions (such as turn left at Wood Lane) and notes about local history.

The maps offered walks covering varying distances from one to four miles. They were designed using a pedometer (someone walked the course) and maps giving local contours. Accompanying notes indicate the energy that would be used for each walk and an indication of fitness in five categories ranging from very unfit to very fit. Advice from Loughborough University suggested the use of metabolic equivalents (METS) to assess the walks in terms of their difficulty. Sponsorship from local companies supported the preparation and printing of the leaflets. The first package of *Health Walk*s was launched in August 1995: the guides were sold for £10 for a set of eight walks.

Despite the care which had been taken to design and grade the walks, they did not seem to be having an effect. While patients were buying the leaflets, few were seen walking! In October 1995 questionnaires were sent to a sample group of patients from the practice list to find out why patients were not walking: what were the blocks and barriers? The questionnaires prompted an encouraging response with over 70% (400) of the forms returned.

Sonning Common: reported barriers to walking as exercise

- People did not think that walking was proper exercise
- Difficulty with climbing over styles – over 50% of people had not climbed a stile in the previous six months
- Concern about getting lost
- Over 70% of the women felt vulnerable when out alone

Health Walks: the positive impact

- People now walk for short journeys rather than use their cars
- Increased awareness of fitness levels.
- Enjoyment of exercise
- Knowledge of the benefits of brisk walking.
- Awareness of the benefits of regular exercise.
- Awareness of the countryside code.

Health Walks: Reported health benefits

- About 10% reported decreased levels of illness.
- About 25% reported reduced their stress levels.
- About 60% reported higher stamina levels.
- About 55% reported higher energy levels.

The replies to the questionnaire were discussed at a public meeting in the village hall in January 1996. About 200 people attended the meeting, a splendid turnout. The idea of health walks was supported and a group of local people agreed to help develop it further. The key points from the subsequent discussions were the need to teach people to walk (they seemed to have forgotten how!), for someone to organise the walks and for the programme to be graded to reflect patients' health and strength. *The key to success might be to move from graded to guided walks.*

A local fitness instructor was recruited to organise the walks and recruit volunteers to act as guides. Local sponsorship supported the training for volunteers. This training included resuscitation training and ensured that they were aware of the health benefits of walking and understood the countryside code. A modified programme was launched in April 1996.

Are people walking?

Since the re-launch of *Health Walks* the programme has gone from strength to strength. The initiative is increasingly a community initiative with volunteers forming a management committee to take over the running of the programme. *Currently, about 100 people are involved every week in one of a dozen walks*. A new timetable is published every three months. Since April 1996, 12,000 walkers have taken part in guided walks: over 800 individuals. A project register is kept to show who is involved and allow progress to be monitored.

The objective was to set up the programme as a health promotion scheme, not as a research project. Nevertheless arrangements were put in place to measure the impact of the project. The practice set up a number of surveys and fitness tests between May 1995 and August 1996. Oxford Brookes University was invited by the Countryside Agency to complete an independent evaluation to quantify the benefits of promoting health walks in the community.

The evaluation found over three-quarters of the participants reported positive impacts of Health Walks and significant

health benefits (Box). The surveys showed that taking part in fitness tests over time significantly increased the fitness levels of participants regardless of whether they took part in Health Walks. The evaluation provided useful information about setting up new walking schemes.

The initiative has attracted much interest and the nearby Wokingham District Council launched a similar scheme covering its population of about 50,000 in October 1997. A full time co-ordinator is now in post there and is gradually creating a significant Health Walks programme. Funding from the Britsh Heart Foundation and the Countryside Agency has enabled this project to be set up as a randomised trial. This will ensure that the programme is rigorously evaluated. The first results of the trial are due to be published late in 1999.

The initiative attracted the interest of the Countryside Agency from the outset. More recently, as a consequence of the success of Health Walks, the Agency and the British Heart Foundation have created a national initiative *Walking the way to Health*. The aim is to create 200 walking schemes in the UK ober the next five years, and financial support for these schemes will be available. The Agency has published *Practical Guidelines for developing Walking for Health schemes* to help others develop local schemes.

Tips for Success

- √ Involve the community from the beginning. Look for volunteers but recognise that it might take time to build their confidence to run the scheme.
- √ Plan how and when 'ownership' will pass to the community.
- √ Be realistic about what volunteers can do. A project co-ordinator (full or part time *and* paid) may make the process go smoother.
- √ Listen to what people are saying and adapt your plan to respond to their concerns.
- √ Make use of free local resources like footpaths and local parks when planning exercise projects. You don't need expensive equipment.
- √ Remember that walking *as physical exercise* is important. Inactivity is as high a risk factor as smoking, high cholesterol, and high blood presure.
- √ Remember that walking is as effective as other forms of exercise when seeking to improve cardiac health.

Contacts - to find out more

For information about the initiative at Sonning Common.

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♦ Copies of the Health Walks guides are available.

For information about developing healthy walk schemes

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Copies of *Practical Guidelines for developing Ealking for Health schemes* are available.

ImpAct bottom line

⇒ **Work with volunteers from the community to keep developments going, but be sure that the community supports the endeavour.**